

INDIVIDUAL PROFESSIONAL FILE - PROFESSIONAL NURSES  
CLINICAL APPRAISAL REPORT (CAR)

1. INDIVIDUAL DEMOGRAPHICS

Name: \_\_\_\_\_

Period Covered: \_\_\_\_\_ to \_\_\_\_\_ Grade: \_\_\_\_\_

Primary/secondary subspecialty codes: \_\_\_\_\_

Mobilization billet: \_\_\_\_\_

2. FACILITY DEMOGRAPHICS

Reporting Activity: \_\_\_\_\_

Department/Directorate: \_\_\_\_\_

Position and Clinical Assignment: \_\_\_\_\_

Purpose of Report: \_\_\_\_\_ Current/every 2 years

\_\_\_\_\_ Transfer/separation

\_\_\_\_\_ AT/ADSW/TAD

3. PROFESSIONAL DEVELOPMENT

Number of papers published/professional presentations: \_\_\_\_\_ /

Number of continuing education credit hours awarded: \_\_\_\_\_.

Recognitions of positive professional achievement (attach explanation/comments): \_\_\_\_\_

4. SCOPE OF CLINICAL RESPONSIBILITY

Major patient population served: \_\_\_\_\_

Age/sex/unique features of population served (retired, geriatric, recruits, etc.): \_\_\_\_\_

Acuity Level: \_\_\_\_\_

Avg. length of stay for major population served: \_\_\_\_\_

Avg. outpatient visits: \_\_\_\_\_

5. CLINICAL PERFORMANCE

<b>Evaluation Elements</b>	<b>Sat</b>	<b>Unsat</b>	<b>N/O</b>
a. Basic professional knowledge			
b. Technical skill/competence			
c. Professional judgment			
d. Ethical conduct			
e. Participation in staff/department/committee meetings			
f. Ability to work with peers and support staff			
g. Ability to supervise peers and support staff			

RE:

6. OTHER INFORMATION (Attach a separate sheet with fully detailed amplification of any Yes answers below). To your knowledge, during this reporting period, has the provider:

	Circle Yes or No	
Had clinical certification or functions suspended, limited, or revoked?	Yes	No
Received a formal letter of warning regarding clinical performance?	Yes	No
Been the primary subject of a malpractice action, claim, a JAGMAN investigation, or healthcare review inquiry?	Yes	No
Had substandard care substantiated through one of the actions noted above?	Yes	No
Required counseling, additional training or special supervision in response to performance, quality monitoring, or legal problems?	Yes	No
Been the subject of a disciplinary action for misconduct?	Yes	No
Required modification of job assignment due to unsatisfactory performance?	Yes	No
Failed to obtain appropriate consultation?	Yes	No
Required modification of job assignment due to health status?	Yes	No
Been diagnosed as being alcohol and/or drug dependent, or having any organic mental disorder or psychotic disorder?	Yes	No

Describe trends, positive or negative, identified through the Command QA Program: **(Must Be Completed)**

**Comment on provider's clinical abilities.**

---

---

---

---

---

---

7. SIGNATURE BLOCK

Title	Signature	Attached	Date
Division Officer			
Staff Member			
Department Head			
Director			